

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN3315	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/25/2011
NAME OF PROVIDER OR SUPPLIER SODDY-DAISY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 701 SEQUOYAH ROAD SODDY-DAISY, TN 37379		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	Initial Comments During the annual Licensure survey and Complaint investigation TN00027109, conducted on May 23, 2011, through May 25, 2011, at Soddy Daisy Healthcare Center, no deficiencies were cited under chapter 1200-8-6, Standards for Nursing Homes.	N 000			

Division of Health Care Facilities

Kind Monty
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

administrator

(X6) DATE

6/7/11

STATE FORM

6899

S7Q611

If continuation sheet 1 of 1

JUN 09 2011